DCH/LMD-504 (09/04)

Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918

# MEDICAL LICENSURE BY ENDORSEMENT INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

**NOTE**: It is your responsibility to have all required documentation sent to the Board of Medicine. Questions regarding your application can be directed to the Michigan Board of Medicine at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

**IF YOU HAVE BEEN LICENSED IN ANOTHER STATE AND HAVE BEEN ENGAGED IN THE PRACTICE OF MEDICINE FOR AT LEAST 10 YEARS, THE FOLLOWING MUST BE SUBMITTED:**

1. A completed application for medical license, and controlled substance license if desired, on the enclosed forms. Please be sure to check that you are applying for license by endorsement and controlled substance license, as applicable.

2. A check or money order, drawn on a U.S. financial institution (made payable to the **STATE OF MICHIGAN)** in the amount of $150.00 for a medical license only or a total of $235.00 if also applying for a controlled substance license. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

3. Official verification of your medical license status submitted directly to the Michigan board from the state licensing board of EACH state in which you currently hold or have ever held a permanent license. Most states charge a fee for providing license verification.

**IF YOU HAVE BEEN LICENSED IN ANOTHER STATE AND HAVE PRACTICED MEDICINE FOR LESS THAN 10 YEARS AT THE TIME OF YOUR APPLICATION, THE FOLLOWING DOCUMENTS MUST BE SUBMITTED IN ADDITION TO THE ONES LISTED ABOVE:**

1. An official score report for the examination that you took to obtain licensure, submitted directly to the Board of Medicine from the examination agency. Score reports must be sent from either the Federation of State Medical Boards at (817) 868-4000, website: www.fsmb.org or the National Board of Medical Examiners (if tested May 1994 or earlier) at (215) 590-9700, website: www.nbme.org.

2. Certification of successful completion of two years postgraduate clinical training in an approved program in a Board approved hospital or institution. The Certification of Postgraduate Training form (attached) must be submitted directly to the Board from the Director of Medical Education where you completed your postgraduate training.

3. If you are a graduate of a foreign medical school, in addition to #1 and #2 above, we must also receive a copy of your ECFMG certification.

4. Official verification of your medical license status submitted directly to the Michigan board from the state licensing board of EACH state in which you currently hold or have ever held a permanent license. Most states charge a fee for providing license verification.

**Note: All postgraduate clinical training programs accredited by the Accreditation Council of Graduate Medical Education (ACGME), the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or the National Joint Committee on Accreditation of Pre-registration Physician Training Programs of the Canadian Medical Association are approved by the board. All hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) are board approved.**

## FCVS

The Michigan Board of Medicine now accepts the Federation Credentials Verification Service (FCVS) to provide documentation for endorsement applications for applicants licensed less than 10 years in another state. The Federation of State Medical Boards (FSMB) makes this service available to applicants. The FCVS verifies a physician's basic credentials with primary sources. Those credentials include postgraduate training, examination history, ECFMG certification and board action history. FCVS does NOT provide licensure verification from other states. Verification information must be sent as specified in #4 above.

**Please note that the use of the FCVS is strictly voluntary on the part of the applicant. The Michigan Board of Medicine reserves the right to request additional information from the applicant during the application review process.**

If you are interested in receiving more information or have any questions regarding this service, please contact the FSMB at (888) 275-3287, website www.fsmb.org.

You are advised that an application for licensure **WILL NOT BE CONSIDERED UNTIL ALL REQUIRED DOCUMENTATION IS SUBMITTED.**

ORIGINAL LICENSES WILL EXPIRE ON JANUARY 31 OF THE FOLLOWING YEAR. SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

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DCH/LMD-040 (03/04)

# APPLICATION FOR MEDICAL DOCTOR LICENSURE

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

| Board Use Only |
|---|
| License Number |
| Date of Licensure |

**Type or Print Only**

**I AM APPLYING FOR THE FOLLOWING (Check One Only):**

☐ **License by Examination Fee: $150.00 71-4301-01**

☐ **License by EndorsementFee: $150.00 71-4301-09**
**(Must currently be licensed in another state )**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

| | | |
|---|---|---|
| First Name | Middle Name | Last Name |
| U.S. Social Security Number | Date of Birth | Michigan Permanent I.D. Number and Expiration Date |
| Street Address | | |
| City | State | ZIP Code |
| Daytime Phone Number | All Previous Names and/or Birth Name Used (if applicable) | |

**Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.**

| | | |
|---|---|---|
| 1. Have you ever been convicted of a felony? | ☐ Yes | ☐ No |
| 2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years? | ☐ Yes | ☐ No |
| 3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)? | ☐ Yes | ☐ No |
| 4. Have you been treated for substance abuse in the past 2 years? | ☐ Yes | ☐ No |
| 5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period? | ☐ Yes | ☐ No |
| 6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period? | ☐ Yes | ☐ No |
| 7. Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? | ☐ Yes | ☐ No |
| 8. Have you ever been denied the privilege of taking an examination by any state medical board? | ☐ Yes | ☐ No |

Name

9. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privilege involuntarily modified? ☐ Yes ☐ No

10. Do you hold or have you ever held a permanent medical license in any state? ☐ Yes ☐ No
If yes, list the state(s) in which you hold or have held a medicine license, the license or registration number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets, if necessary)**

| State | License Number | Date of Issue | How obtained (Endorsement or examination) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Provide a complete chronological record of your educational preparation.**
Attach additional sheets if necessary.

| Name and Address of Institution | Dates of Attendance From | To | Degree |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Provide a description of your professional medical experience.**
Attach additional sheets if necessary.

| Name and Address of Employer | Dates of Practice From | To | Duties |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of their pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

| Signature of Applicant | Date |
|---|---|
| | |

Michigan Department of Community Health
**Board of Pharmacy**
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

DCH/LPH-090 (07/04)

| Board Use Only |
|---|
| Date of Licensure |
| License Number |

# CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, prescribe, or dispense controlled substances. If you are an M.D., D.O., D.P.M., D.D.S., O.D. or D.V.M. who prescribes at more than one location, a controlled substance license is required for each location. Please submit a separate application for each location.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

**Type or Print Only**

## INSTRUCTIONS

1. **CONTROLLED SUBSTANCE FEE: Initial (first time) professional license or relicensure of your professional license - $85.00.**
   **If you already hold a professional license and your professional license expires in:**

   **0-12 months the fee is $85.00 (13757)** **13-24 months the fee is $160.00 (23757)** **25-36 months the fee is $235.00 (33757)**

2. **M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.**

3. **Allow up to six weeks for your paper license to arrive.**

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

| First Name | Middle Name | Last Name |
|---|---|---|
| | | |

THIS LICENSE VALID - ONLY AT THE FOLLOWING LOCATION

| Street | | Telephone Number |
|---|---|---|
| City | State | ZIP Code |

## TYPE OF PROFESSIONAL LICENSE

(Please Check One):

| | Regular | | Educational Limited |
|---|---|---|---|
| ☐ **29 - 01 D.D.S. 71-5315** | ☐ | or | ☐ |
| ☐ **59 - 01 D.P.M. 71-5315** | ☐ | or | ☐ |
| ☐ **69 - 01 D.V.M. 71-5315** | ☐ | or | ☐ |
| ☐ **43 - 01 M.D. 71-5315** | ☐ | | |
| ☐ **51 - 01 D.O. 71-5315** | ☐ | | |
| ☐ **49 - 01 O.D. 71-5330** | ☐ | | |
| ☐ **53 - 01 Pharmacy Store 71-5301** | ☐ | | |
| ☐ **53 - 02 R.Ph. 71-5302** | ☐ | | |
| ☐ **53 - 06 Manuf./Wholesaler 71-5306** | ☐ | | |

## STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**

   ☐ **Yes** ☐ **No**

   **If Yes, please explain on separate sheet.**

2. **Is your current professional license limited as a result of Board disciplinary action?**

   ☐ **Yes** ☐ **No**

| Michigan Permanent I.D. Number (as shown on your pocket card) | |
|---|---|
| Expiration Date of License | Social Security Number |

**I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.**

| Signature | Date |
|---|---|
| | |

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**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918



# CERTIFICATION OF POSTGRADUATE TRAINING

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

## INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

## SECTION I - APPLICANT INFORMATION

| | | |
|---|---|---|
| First Name | Middle Name | Last Name |
| Social Security Number | Date of Birth | |
| Street Address | | |
| City | State | ZIP Code |
| Daytime Telephone Number | All Previous Names and/or Birth Name Used (if applicable) | |

| | |
|---|---|
| Signature of Applicant | Date |

**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.**

Name

## TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

### INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

### SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital

Street Address of Hospital

City, State and ZIP Code

I certify that ______________________________ a graduate of the
(Applicant's Name)

______________________________ medical school, has successfully completed postgraduate

clinical training offered by the hospital named above from ______________ , to ______________ ,
(Month/Day/Year) (Month/Day/Year)

in the clinical area of ______________________________ .

Is this training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? ☐ Yes ☐ No

______________________________
Signature of Director of Medical Education

______________________________
Date of Signature

______________________________
Print or Type Name of Director of Medical Education

(S E A L)

If hospital has no seal, please indicate

NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.

OHS/HLD-001 (01/04)

Michigan Department of Community Health
**Bureau of Health Professions**
P.O. Box 30670
Lansing, MI 48909

# VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

**PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.**

**Check the profession for which you are requesting verification.**

| | | | |
|---|---|---|---|
| ☐ Chiropractic | ☐ Nursing | ☐ Pharmacy | ☐ Sanitarians |
| ☐ Counseling | ☐ Nursing Home Adm. | ☐ Physical Therapy | ☐ Social Work |
| ☐ Dentistry | ☐ Occupational Therapy | ☐ Physician's Assistants | ☐ Veterinary |
| ☐ Marriage & Family Therapy | ☐ Optometry | ☐ Podiatry | |
| ☐ Medicine | ☐ Osteopathy | ☐ Psychology | |

| | | |
|---|---|---|
| First Name | Middle Name | Last Name |
| Previous Names Used | Date of Birth | U. S. Social Security Number |
| State Board | License Number | Date of Issue |

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

**PART II: To be completed by the State Licensing Board.**

| | | |
|---|---|---|
| Basis for Issuance of License:<br>☐ Examination - Please indicate type of exam (National, Regional, State, etc.)<br>☐ Endorsement - Please indicate name of state | | Type of License: |
| License Status<br>☐ Current ☐ Lapsed ☐ Inactive | Original Issue Date | Expiration Date |

Has the applicant incurred any formal or informal actions in your State?

☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

| | |
|---|---|
| Are formal or informal actions pending?<br>☐ No ☐ Yes | Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?<br>☐ No ☐ Yes |

## CERTIFICATION

**I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.**

**Signature** ______________________ **Date** ______________________

**Type or Print Name** ______________________

(S E A L)

**Title** ______________________

**Full Name of Licensing Board** ______________________

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.